Office of Care Coordination
VHA Telehealth
NEWSLETTER
August 26, 2004 Volume IV Issue II

Care Coordination Strat Mtg Held

VHA's Office of Care Coordination convened a Strategic Planning Meeting July 20 and 21, in Washington D.C. VISN Care Coordination representatives and VA leadership including representatives from the Employee Education System, Office of Information, Office of Nursing, Mental Health, Geriatrics & Extended Care, Medical/ Surgical Strategic Health Care Groups, Prosthetics, the National Acquisition Center, HSR&D, and the Office of Care Coordination. The group gathered to discuss near and long-term support strategies for VHA's 21 regional Care Coordination programs. Five breakout sessions identified the Clinical, IT, Training (Pictured right) , Business, and Research needs of Care Coordination, and the strategies to meet those needs.

Care Coordination Strategic Planning Meeting Group 3: Training

VHA's Kristin Davis, Rita Kobb, Donna Vogel and Sydney Wertenberger
Backed by EES's Robert Lane, Terry Fox, and Lynn Ward

VHA Telerehabilitation Group Forms

Cathy Cruise,MD

VHA's Telerehabilitation Field Work Group met for the first time, on August 2nd, to begin their work creating resources (e.g., start-up program toolkit, Web site, etc) to support VHA rehabilitation services through telehealth technologies. OCC's Dr. Adam Darkins and Dr. Barbara Sigford, VHA's Program Director for Physical Medicine and Rehabilitation (PM&R) welcomed the group. As VHA's Lead for Telerehabilitation, I will chair the Work Group that includes one representative from each of VHA's 21 VISN's. The group members bring a range of experience and perspectives including: audiology, speech pathology, occupational and physical therapy, braces, amputation, and spinal cord injury. The group is very enthusiastic about strategic planning for both home- and clinic-based telerehabiltation applications.

IN THIS ISSUE:

VHA Office of Care Coordination: A Year On

By Adam W. Darkins, MD

VHA established the Office of Care Coordination (OCC) in July 2003. This new Office incorporates Telehealth and also provides support to VHA's Social Work Service. The mission of the office is to help ensure veteran patients receive the right care at the right place and at the right time. The benefit that better coordination of care can bring to the delivery of health services has been clearly outlined by the Institute of Medicine in its publication Priority Areas for National Action: Transforming Health Care Quality. The use of new technologies in the form of health informatics, telehealth and disease management helps coordinate the biological elements of care provision. And Social Work incorporates the important psycho-social elements to care into the work of OCC by working in an interdisciplinary fashion with other professional groups.

Adam Darkins, MD
is the Chief Consultant for VHA's Office of Care Coordination & VHA's Telehealth Strategic Health Care Group

The definition of care coordination has evolved since OCC was formed and defines where this new entity of care coordination sits relative to existing care and case management activities. The current definition of care coordination is: Care coordination is the wider application of care and case management principles to the delivery of health services using health informatics, disease management and telehealth technologies to facilitate access to care and to improve the health of designated individuals and populations with the specific intent of providing the right care in the right place at the right time. This is a definition of care coordination that applies to health care professionals. It emphasizes that care coordination is not new. It is making existing aspects of health care delivery more widely available using new technologies. The idea that a small new office like OCC would, at a stroke, be able to coordinate the care across a complex and large integrated health care organization like VHA is totally unrealistic. Instead, OCC is initially implementing Care Coordination/Home Telehealth (CCHT) that is aimed at helping support veterans with complex care need in non-institutional health care settings. The intent of this is to try and make the home, whenever appropriate and achievable, the preferred place of care.

In addition to a professional definition of care coordination OCC has also developed a patient definition. This is that:

> The benefit that **better coordination of care** can bring... ...has been clearly outlined by the **Institute of Medicine** in its publication **Priority Areas** for National Action: Transforming Health Care Quality.

Care coordination is a service that includes the use of new information technologies that connect people to health care services that help ensure the right care happens in the right place at the right time. OCC plans to hold patient focus groups to help refine this definition. Why, some people ask, is it necessary to have a patient definition? OCC has felt this to be important because if we are expecting patients to be more involved in their care and to self-manage this care, then surely it is reasonable that they are aware of how we

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VHA Office of Care Coordination: At One Year (Cont'd)

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are helping them to do this? Patients seem less concerned about the fine nuances of professional practice and more with the realities what health care encounters mean for them and the patient definition reflects this concern. OCC intends to expand the area of patient and caregiver information on the OCC website during the next 12 months.

It has been important to define who we are and what we are doing and partner with people, offices and departments throughout VA and work with other federal partners. OCC has been busy and below is a list of notable achievements over the past 12 months.

2003	2003 Accomplishments
July	OCC Established
August	RFP for 6 VISN Projects Released
	Training Center RFP Released
	Above RFP's both Awarded
September	CCHT Patient Census 2,500
	DSS codes for Care Coordination Agreed
	National Caregiver Conference Convened
October	National Technology Contract Solicitation Released
November	"Conditions to Participate" Agreed
December	Technology Solicitation Review Re-Solicitation Following Protests

2004	2004 Accomplishments
January	Clinical Practice Recommendations Finalized with Prosthetics
February	Care Coordination Training Center Opened-Lake City, FL & West Haven, CT
	Patient Census 3,150
	National CC/TH Conference Held
	OCC Web site Launched

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VHA Office of Care Coordination: A Year On (Continued)

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2004 Accomplishments

March	**Panel Re-Reviewed National Technology Solicitation Submissions**
April	**CCHT Census 3,500**
May	**VHA Telemental Health announced activity data revealing 8,000 veterans received care in over 13,000 telemental health visits in 2003**
	On-line Training for Care Coordination/Home Telehealth Goes Live
	RFP's Issued for 10 New Programs
	VHA Leads for Telemental Health, Telerehabilitation, and Telesurgery announced.
June	**National Technology Award Made**
July	**Vendor Protest Made to GAO against National Technology Award**
	Contract Waiver Issued by OCC and Prosthetics
	RFP's Awarded for 10 New Programs
	5 VISNs Assessed for Conditions to Participate since November 2003
	OCC National Strategy Meeting Held in Washington DC
August	**USH and NLB Authorized national tele-retinal imaging program in VHA to assess patients for diabetic retinopathy**
	Vendor Protest resolved by GAO; VHA national home-telehealth contract upheld
	CCHT Patient Census 4,000
	National VHA Telerehabilitation Field Work Group Formed

OCC gratefully acknowledges the help and support of offices, individuals throughout VA at the facility, VISN and national level for making these achievements possible and looks forward to much more productive collaboration in the future.

Care Coordination Home Telehealth CCHT Training Center

New Collaboration for Sunshine Training Center

By Rita Kobb, MN

Training Center Director
Education Prog Spec

The national training center in Lake City, Florida has established a collaborative relationship with the Center for Telehealth and Healthcare Communications at the University of Florida (UF) in Gainesville. Training Center staff will serve as consultants to the center on home telehealth and will also participate as chair of the telehealth section in an international aging and technology conference scheduled for Florida in 2006.

The Center for Telehealth's mission is to facilitate collaborative multidisciplinary research on distance approaches to healthcare services, education, and research. The UF Center supports scientific investigation and clinical training in telehealth by providing specialized technology research, educational, and clinical support services. The Center for Telehealth is housed in the College of Public Health and Health Professions. They offer stand-alone video conferencing network and video streaming capabilities. The Center's objectives include:

· Promote scientific investigation of the effects of telecommunication technologies on the quality, outcomes, and cost utility of health care practice

· Develop and disseminate training curricula in the science and practice of telehealth

· Provide consultation on the development and evaluation of distance approaches to healthcare

· To serve as a conduit for educating communication technology vendors about the specific needs of telehealth providers and consumers

Some of the Center's projects include:

AlzOnline www.alzonline.net Alzheimer's Caregivers Support Online provides on-line education & support classes to caregivers of elders with dementia.

Rehabilitation Engineering Research Center on Technology for Successful Aging (RERC) www.rerc.ufl.eduThe Center identifies needs and barriers to home monitoring and communication technology for elders.

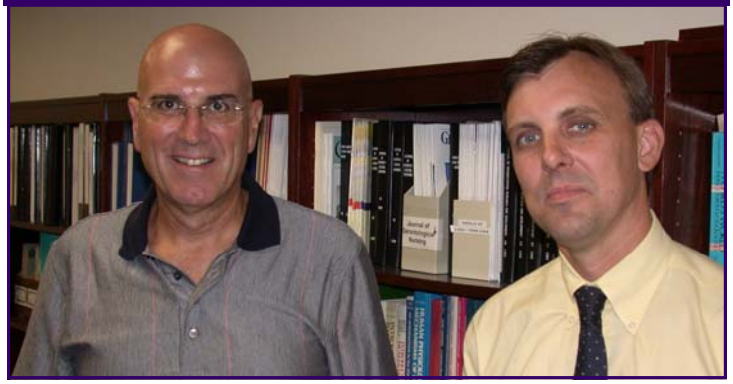
Florida Older Drivers Project www.hp.ufl.edu/fdot Provides web-based assistance for older drivers for safety and driving cessation.

The **National Training Center**... ...has established a **collaborative relationship** with the **Center for Telehealth and Healthcare Communications** at the **Univ of Florida**.


CCHT National Training Center, Lake City, FL


UF College of Public Health & Health Professions, Gainesville, FL

UF Center for Telehealth & Healthcare Commnunications


Dr. Bill Mann, Director **Jeff Loomis**, Associate Director

Upcoming Conferences

Details OnLine at http://www.va.gov/occ/Conferences.asp

VHA National 2004 Care Giver Conference

November 16-18 Arlington, VA

Care Coordination & TeleHealth Leadership Forum 2005

Salt Lake City

Knowledge NETWORK Knowledge NETWORK Knowledge NETWORK

1. Coming Thursday September 16

CARE COORDINATION/TELEHEALTH

VHA TeleEndocrinology

Thursday September 16 (2PM Eastern)

Taped Rebroadcasts

Monday—September 20—11 AM Eastern

Wednesday—September 22—3 PM Eastern

Monday—September 27—12 Noon Eastern

2. Coming Thursday October 14

CARE COORDINATION/TELEHEALTH

VHA Telehealth & VERA

Thursday October 14 (1PM Eastern)

Taped Rebroadcasts

Wednesday—October 14—1 PM Eastern

Monday—October 25—11 AM Eastern

Tuesday—November 2—3 PM Eastern

Knowledge NETWORK Knowledge NETWORK Knowledge NETWORK

VA Employees may see complete program details in the

Employee Education System Learning Catalog vaww.sites.lrn.va.gov/vacatalog/

VHA Telehealth Trailblazers

DONNA VOGEL

Leading Care Coordination for VISN 1

I first met **Donna Vogel** five years ago, shortly after I came to work for the VA. Since then, lucky for me, our paths have crossed numerous times. We have collaborated on home telehealth workload credit guidance in Washington, DC, co-presented on telehealth at VA's IT Conference in Austin, TX, and shared at least one frantic rental car ride to the Tampa airport. As you will read in the interview beginning on page 9, no matter where she is, or which role she is playing, including her current role of **leading Care Coordination in VISN 1**, Donna is always **gracious, enthusiastic, balanced,** and truly **one of the best parts of today's VHA...**

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VHA Telehealth Trailblazers

John Peters: *Donna, I know you are busy with a lot of things up in West Haven, so, first off, thanks for taking the time out for this interview. I guess I have known you for just about five years now, but you have been with the VA a little longer than that, when and where did you begin your career with the VA?*

Donna Vogel: I began my career at the Newington (CT) VAMC after graduating from college. I first worked on a busy 32 bed surgical ward and later became the Surgical Intensive Care Unit (SICU) Nurse Manager. I left in 1982 to raise my family and worked part time as a legal nurse consultant, a consultant and educator for community hospitals, and provided home hospice before returning to the VA. After working in the private sector, I had a new appreciation for the VA and the opportunities it offered, being a recognized leader in research and the largest healthcare system in the country. After returning to the VA, I started the Case Management Program to support the shift from an inpatient care model to an outpatient patient-centered, primary care model. The case management program proved to be very effective, demonstrating improved length of stays, clinical outcomes, patient and provider satisfaction and reduced healthcare costs. Telehealth was later implemented as part of the case management program to extend primary care and augment home care, provide more frequent monitoring and timely intervention, improve access to care, and allow case managers to provide services to even more patients. The positive outcomes of telehealth led to our applying for VHA's Health Services Research & Development (HSR&D) funding and later, Multi-VISN Project (MVP) funding.

The national rollout of CCHT not only provided us with funding to purchase equipment, but more importantly provided the opportunity to collaborate with and learn from other networks...

JP: *I know VA Connecticut has been doing home telehealth for years and, based on that experience, your VISN became something of a demonstration project for Care Coordination in 2002. Can you briefly describe VISN 1's approach to Care Coordination, the scale and scope of your current program, and your plans for the next year or two?*

DV: We saw Care Coordination Home Telehealth (CCHT) as an opportunity to expand case management services. CCHT was implemented using the existing service line infrastructure. Care managers took a lead role in implementation including patient selection, enrollment, monitoring and intervention. Home telehealth technology was recognized as a necessary tool to expand care management. Although we were early adopters of home telehealth and had IT expertise to support the program, after our HSR&D funding was used, we were unable to fund additional equipment and support staff. This limited our ability to expand CCHT and we were very pleased to receive funding for the MVP. The national rollout of CCHT not only provided us with funding to purchase equipment, but more importantly provided the opportunity to collaborate with and learn from other networks, serve a much larger population, and to implement new technology such as interactive voice response (IVR) and video conferencing. We enrolled almost 800 patients in seven of our eight facilities. We have technology in place at residential living facilities and transitional veteran housing to improve access for and communication with our patients. We completed the Conditions of Participation, had the opportunity to help develop VHA's home telehealth toolkit, and work with Network 8 to develop curriculum and web-based training for the national training

VISN 16 Trailblazers

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center. We also developed a Care Management/Care Coordination Information System (CMIS) to prospectively identify high-risk, high cost patients that could benefit from CCHT. The CMIS provides important provider, case manager, and insurance contact information and utilization, and costing data to ensure safe, appropriate, and in-time access to care. CMIS offers several SSN specific information and patient population reports based on chronic disease, cost, facility, age, gender, VERA Class, provider and/or case manager. It has improved case managers' efficiency and productivity by decreasing the time to identify critical patient information, enabling a 15% increase in caseload. This, in turn, improves patient safety through timely access to care. To date our focus has been on patients with Congestive Heart Failure (CHF), Diabetes Mellitus (DM), hypertension, Chronic Obstructive Pulmonary Disease (COPD), chronic pain and end stage renal disease. Our goal is to expand CCHT to support palliative care, SCI, and mental health care.

JP: *Many people, from both inside and outside the organization, who are watching VHA's national roll out of Care Coordination seem to be looking for numbers, Has VISN 1 been looking at outcomes data or business case data?*

DV: Yes we have. Utilization data for patients on CCHT showed a 40% decrease in bed days of care after a six month period. Patients on CCHT for management of hypertension show a 70% improvement with an unchanged or diminished BP range value; 89% of the patients with diabetes experienced an A1C value that was decreased or held to changes <=1.0; and 85% of patients with congestive heart failure reported feeling more in control of their condition and had a 58% decrease in healthcare costs. Patient satisfaction was significantly improved for patients enrolled on CCHT. Using the patient satisfaction survey approved by OCC, 97.8% of the 146 patients surveyed reported the technology easy to use. Importantly, using the technology to monitor patients allowed us to increase the number of patients we can follow and manage in the home and community. Our caregivers are very appreciative of CCHT and report that home telehealth has decreased the need for travel to the clinic - which can very difficult and stressful for frail, unstable patients, and has greatly improved communication with their clinician.

Patients on CCHT for management of hypertension show a 70% improvement with an unchanged or diminished BP range value...

JP: *I want to point out that, as trailblazers, you and your Office of Information recognized early on the critical importance of integrating health information data, generated by home telehealth devices, into the VA's information system (VistA/CPRS). Can you talk a little bit about how you were able to accomplish that and the talk about the various roles of the participants (e.g., Clinicians, OI staff, vendors)?*

DV: Our VISN was one of the first to look at non-traditional ways of extracting data *from* VistA. We started a network-wide data warehouse to provide more timely utilization and provider activity data. The tools we were able to create also wrote data back *into* VistA tables. Others in the VA had also begun to use this approach, most notably Kevin Magee, then of VISN 21's San Francisco VA. When our first telehealth project began, we saw the potential for a much wider use of telehealth and began to think of how it might fit into the VA's evolving care models. Our CIO, Dr. Joseph Erdos, had always seen the VA's Electronic Patient Record (EPR) as an invaluable tool for quality healthcare and had been a strong promoter of CPRS. He realized early on that telehealth would grow and that maintaining the integrity of the patient's electronic record would be critical. He directed his technical staff to design a method to write telehealth data to VistA. In 1999 (about 5

VISN 16 Trailblazers

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years ago) home telehealth vital sign data was on the CPRS coversheet. This work was done with the support of Panasonic Corporation and later Viterion TeleHealthcare, which worked closely with the IT team supporting this effort.

JP: *I am sure you have had a lot of wonderful experiences over the last few years, can you share any quick lessons learned for others just starting up?*

DV: Staff and patient education is key for program success; Good relations with the vendor is critical; A few primary care telehealth champions go a long way; Simpler is better for promoting patient compliance and obtaining staff buy-in; and start small to achieve success and encourage further growth

JP: *Can you pick one episode or one story about a veteran enrolled in home telehealth that made you really appreciate the possibilities of telehealth?*

DV: We have so many success stories it is hard to select one. I will share the impact CCHT has had on a 77 year old, 100% Service Connected (SC) disability, homebound spinal cord injury patient with hypertension and diabetes who three years ago was contemplating nursing home placement. His chronic disease required frequent monitoring and follow up visits to the VA and this was becoming more difficult for the patient and a hardship for the family. **Six months prior to starting CCHT he was hospitalized three times and had four ER visits**. Reluctant to accept nursing home placement, he was offered home telehealth to augment his home care services and provide frequent monitoring and videoconferencing visits to access care to minimize to travel to the VA. **Since enrolling in home telehealth, over three years ago, this patient has had one ER visit and hospitalization.** On several occasions, he has had elevated blood sugars and clinicians were able to provide timely intervention thereby avoiding complications. On another occasion the care manager identified that he was taking medication from a prescription filled earlier and not taking the currently prescribed dosage. Interventions have included medication management, coordinating care for elevated blood sugars, and providing education about skin care, signs and symptoms of hyper and hypoglycemia and compliance with diet. "Advice" messages are sent to provide positive feedback and encourage self-management. Videoconferencing sessions are scheduled when support from social work, a pharmacist, registered dietician and/or medicine is needed. He has even been able to get his wheelchair repaired by sending a photo of the broken piece for the nurse care manager and prosthetics supervisor to view. The part was ordered and mailed to the patient's home avoiding travel to medical center.

JP: *As far as telehealth, I think of you as focused primarily on home telehealth. First is that true? And second, do you ever get involved with other VA Connecticut or VISN 1 telehealth programs? (e.g., CBOC Telemental Health; Telerehabilitation; Teledermatology)*

DV: That is true; I have focused on home telehealth and am not directly involved in other telehealth programs. However, Network 1 has several other telemedicine programs that serve the needs of veteran patients beyond the home environment. They include digital retinal photography employing the Joslin Vision Network (JVN), teleradiology and diagnostic imaging, and teledermatology. Through a JVN project, digital retinal imaging has been deployed at two facilities and will soon be available in some CBOCs that do not have eye clinics available on-site. The benefits of teleretinal screenings is that patients with diabetes have access to retinal screenings in the ambulatory care setting without needing a separate visit to an eye care professional. The VistA Imaging program is

VISN 16 Trailblazers

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available to all sites that support inter-hospital image sharing. The modalities effected range from traditional chest X-ray machines and CAT (Computed Axial Tomography) scanners to MRI (Magnetic Resonance Imaging), endoscopy, dermatology, and ophthalmology. Providers no longer have to wait days for films to arrive from another facility. The Network's Wide Area Network (WAN) supports high-speed protocols that deliver complex CAT scans or other imaging in minutes. Tele-dermatologic services are provided from Rhode Island to support veterans in Maine where there is a shortage of dermatologists.

JP: *Telehealth crosses a lot of boundaries within a health care delivery system and other VISNs have established a dedicated VISN Telehealth Coordinator and a formal Telehealth Committee to link the clinicians with the OI techologists with the administrative workload coders with the credentialing staff, et al – while others use a more ad hoc approach. How would you characterize VISN 1's approach to telehealth?*

DV: Ours began as a grassroots effort. Home Telehealth was first implemented at Connecticut Healthcare System (CHCS) and the network-wide rollout initiated when we received MVP funding. A network level committee was formed and network leadership identified CCHT as one of the network's top three strategic initiatives. Staff at Connecticut HCS provided leadership and administrative oversight to help implement CCHT network-wide. However, with the plan to increase enrollment and implement CCHT at all sites, it became evident that network level support was needed. The Network Chief Medical Officer (CMO), Dr. Michael Miller and Director for Geriatric & Extended Care Corrine Smith took a lead role to support successful implementation. An IT Telehealth Coordinator, Home & Community Based Care Coordination Manager, and Health System Specialist positions were approved to support CCHT.

JP: *What are you working on now or planning for VISN 1 that has you most excited?*

DV: We are planning to provide CCHT for patients with mental health disease, spinal cord injury and dysfunction, and palliative care needs.

JP: *Finally, because over the years I have become vaguely aware of some of what you do for VHA, I have to ask: How do you get it all done in a day? What's your secret to balancing work and home life? And where do you get your energy? Are your folks/siblings the same way (is this genetic)? Or is this something unique to you?*

DV: I think the secret is liking what you do – and I love what I do. I have always been very committed to family and friends, doing for them is very gratifying and energizes me. In my professional life, I love working for our veterans. I also appreciate the opportunity to work with the talented care management and telehealth team - they are inspirational. Like my dad, I have always had a high energy level and a big advantage is that I do not require much sleep, giving me more time to get things done.

Thank you for giving me an opportunity to share our program. This is an exciting time in the VA, on the leading edge of innovative use of technology to move the locus of care for management of chronic disease from the hospital to the home and improve quality of care while addressing patients' needs and preferences.

VHA TELEMENTAL HEALTH

Quarterly Update: Panel Presents at Best Practices

By Linda Godleski, MD

The 2004 "VA Best Practices in Network Mental Healthcare Systems" conference was held in Boston on June 24-25. A panel of telemental health clinicians presented: "Telemental Health: Emerging Best Practices in VHA."

In addition to the long-standing history of telemental health videoconferencing to CBOCs and Vet Centers, the presenters focused on cutting edge innovations using telehealth technologies to deliver mental health services within the VA.

As VHA Telemental Health Lead, I chaired the following panel of five speakers:

1. Leslie Anne Morland, Psy.D., Clinical Psychologist and Health Research Scientist at the National Center for PTSD, Pacific Island Division, presented her published work on **PTSD assessments and groups in the Hawaiian Islands**.

2. Daniel Kivlahan, PhD, Director of the VA National Center of Excellence in Substance Abuse Treatment and Education (CESATE) at Puget Sound Health Care System, presented his work on using **Interactive Voice Response (IVR) for symptom monitoring in patients with substance abuse and PTSD.**

3. Donna Vogel, MSN, Program Director for Care Management at the Connecticut Healthcare System, VISN 1 Project Manager for the Multi-VISN Project for Care Coordination/Home Telehealth, gave an **overview of mental health components of the new VISN Care Coordination Projects.**

4. Susan Blaney, BA, BSN, RN, BC, Mental Health Care Coordinator/MHICM RN, Cheyenne VAMC, demonstrated the use of **disease management dialogues with in-home messaging devices in VISN 19.**

5. Larry Lantinga, PhD, Co-Manager Behavioral Care Line, VA Medical Center, Syracuse NY spoke on **innovative collaborations with the Department of Defense utilizing telemental health.**

In addition to… ...telemental health videoconferencing to CBOCs and Vet Centers, the presenters focused on cutting edge innovations...

Dr. Linda Godleski is the Lead for VHA Telemental Health as well as Associate Chief of Staff for Education at the VA Medical Center in West Haven, CT.

Office of Care Coordination

VHA Telehealth

NEWSLETTER

Mission

Serve as a conduit for information sharing,
strengthen resources, and
promote community for telehealth within the VHA,
with the ultimate goal being: to provide the best quality of care to our patients despite the barriers that distance and/or time may impose.

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FeedBack

Please drop us a line and tell us what you think, or make a suggestion about content for future issues. We would love to hear from you. Please contact:
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Next Issue

Coming late November 2004.